

Division of Health Care Facilities

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN3004 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 09/15/2011 |
| NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF GREENEVILLE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 725 CRUM STREET GREENEVILLE, TN 37743 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETE DATE |
| N 000 | Initial Comments Complaint investigation #28647 and #28549 were completed on September 15, 2011, at Life Care Center of Greeneville. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes. | N 000 | | | |

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

KCOV11

If continuation sheet 1 of 1